



National Coverage Determination (NCD 30.3.3): Acupuncture for Chronic Low Back Pain (cLBP)

MLN Matters Number: MM11755 **Revised**

Related Change Request (CR) Number: 11755

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Effective Date: January 21, 2020

Related CR Transmittal Numbers:
R10337NCD and R10337CP

Implementation Date: October 5, 2020 –
Medicare Shared Systems & A/B MACs,
January 4, 2021

Note: We revised this article to change the wording of the Example on page 2. We changed the references in that example to the first service. This change appears in dark red font. All other information remains the same.

Provider Types Affected

This MLN Matters Article is for physicians, providers, and suppliers billing Medicare Administrative Contractors (MACs) for services they provide to Medicare patients.

Provider Action Needed

This article tells you that the CMS will cover acupuncture for chronic Low Back Pain (cLBP) effective for claims with dates of service (DOS) on and after January 21, 2020. Note that we still determine that acupuncture for treatment of fibromyalgia or osteoarthritis isn't considered reasonable and necessary and remain non-covered by Medicare. Make sure your billing staff knows of these changes.

Background

Acupuncture is the selection and manipulation of specific acupuncture points through the insertion of needles or "needling," or other "non-needling" techniques focused on these points. The NCD for Acupuncture (30.3), issued in May 1980, states that Medicare reimbursement for acupuncture, as an anesthetic or as an analgesic, or for other therapeutic purposes, may not be made. Accordingly, acupuncture was not considered reasonable and necessary within the meaning of section 1862(a)(1) of the Social Security Act (the Act). In 2004, we considered the use of acupuncture for fibromyalgia and determined that there was no convincing evidence for the use of acupuncture for pain relief in patients with fibromyalgia (NCD 30.3.1). Similarly, in that same year, we concluded that there was no convincing evidence for the use of acupuncture for pain relief in patients with osteoarthritis (NCD 30.3.2).

In the most recent national coverage analysis for acupuncture specifically targeted for cLBP, we

determined we'll cover acupuncture for cLBP under section 1862(a)(1)(A) of the Act effective for claims with DOS on and after January 21, 2020. Up to 12 visits in 90 days are covered for patients under the following circumstances:

For the purpose of this decision, cLBP is defined as:

- Lasting 12 weeks or longer
- Nonspecific, in that it has no identifiable systemic cause (for example: not associated with metastatic, inflammatory, infectious, etc. disease)
- Not associated with surgery
- Not associated with pregnancy

We'll cover an additional 8 sessions for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually.

Example: If the **first** service is performed on March 21, 2020, the next service **beginning a new year** can't be performed until March 1, 2021. This means 11 full months must pass from the date of the **first** service before eligibility begins again.

Treatment must be discontinued if the patient is not improving or is regressing.

Physicians, Physician Assistants (PAs), Nurse Practitioners (NPs), Clinical Nurse Specialists (CNSs), and auxiliary personnel may furnish acupuncture if they meet the criteria in <https://www.cms.gov/files/document/r10337ncd.pdf#page=7>.

All types of acupuncture including dry needling for any condition other than cLBP are non-covered by Medicare.

Claims Processing General Information

- Effective for claims with DOS on or after January 21, 2020, MACs will recognize and pay for acupuncture for cLBP services reported with CPT codes 97810, 97811, 97813, 97814, 20560, and 20561 as covered services under NCD 30.3.3.
- The applicable ICD-10 diagnosis codes are in the attachment to CR 11755 and one of the above CPT codes must be reported for acupuncture for cLBP services.
- MACs will accept claims with the -KX modifier for an additional 8 services (over and above the initial 12 in 90 days) for up to 20 visits in 12 months. By applying the -KX modifier to the claim, the therapy provider is confirming that the additional services are medically necessary as justified by appropriate documentation in the medical record.

Institutional Claims Bill Type and Revenue Coding Information

- Effective for claims with DOS on or after January 21, 2020, MACs will recognize acupuncture for cLBP services reported on institutional claims on types of bill (TOBs) 012X, 013X, 71X, 77X, and 085X (and revenue codes not equal to 096X, 097X, and 098X for Method 1 Critical Access Hospitals (CAHs)).

- Effective for claims with DOS on or after January 21, 2020, MACs will recognize acupuncture for cLBP services reported with Revenue Code 0940 on institutional claims.
- Effective for claims with DOS on or after January 21, 2020, MACs will recognize acupuncture for cLBP services reported on institutional claims on TOB 085X CAH Method II with revenue codes 096X, 097X, and 098X.
- MACS will reject/deny claims with DOS on or after January 21, 2020, that do not contain the required CPT and ICD-10 diagnosis codes using the following messages:
 - Claim Adjustment Reason Code (CARC) 50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer.
 - Remittance Advice Remark Code (RARC) M64 –Missing/incomplete/invalid other diagnosis.
 - Group Code CO (Contractual Obligations) or PR (Patient Responsibility) dependent on liability.

In addition to the codes listed above, MACs will afford appeal rights to all denied parties.

- MACs will return to provider/return as unprocessable claims for acupuncture for cLBP for more than 12 services per annum without the -KX modifier and use these messages:
 - CARC 4 - The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present
 - RARC N657 - This should be billed with the appropriate code for these services
 - Group Code CO
- MACs will reject/deny more than 20 acupuncture for cLBP claims per annum using the following messages:
 - CARC 96 - Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present
 - RARC N640 - Exceeds number/frequency approved/allowed within time period
 - Group Code CO

MACs won't search for acupuncture for cLBP claims with DOS on or after January 21, 2020, but will adjust claims that you bring to their attention.

More Information

CMS issued the official instruction, CR 11755, via two transmittals. The first updates the Medicare NCD Manual and it is available at <https://www.cms.gov/files/document/r10337ncd.pdf>. The second transmittal updates the Medicare Claims Processing Manual and it is available at <https://www.cms.gov/files/document/r10337cp.pdf>.

If you have questions, your MACs may have more information. Find their website at <http://go.cms.gov/MAC-website-list>.

Document History

Date of Change	Description
October 20, 2021	We revised this article to change the wording of the Example on page 2. We changed the references in that example to the first service. This change appears in dark red font. All other information remains the same.
September 1, 2020	We revised this article to reflect an updated Change Request (CR) 11755 that provides revised messaging (page 3 in this article). It also revised the Claims Processing Manual at Section 410.4.
May 13, 2020	Initial article released.

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